STATE OF HAWAII
DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
DISABILITY COMPENSATION DIVISION

FORM WC-5
(REV 7/92)

EMPLOYEE'S CLAIM FOR WORKERS' COMPENSATION BENEFITS

INJURED PERSON

Name _____

Address _____

Occupation _____

Phone No. _____ Social Security No. _____

EMPLOYER

Name _____

Address _____ Phone No. _____

Nature of Business _____

INSURANCE CARRIER

Name _____

Address _____

INJURY

Date of Accident _____ Time _____ Date Disability Began _____

If not on employer's premises, place where accident occurred _____

_____

How did accident occur _____

_____

Describe injury/illness _____

_____

Reason for filing: ☐ Employer has not filed WC-1 ☐ Reopening of old claim
☐ Insurance carrier has not paid benefits ☐ Others

Explain _____

_____

WITNESS

Name _____

Address _____

NOTICE

Did you give employer notice of injury? ☐ Yes ☐ No

If so, when: _____ How: ☐ Oral ☐ Written

To whom: _____

ATTENDING PHYSICIAN

Name _____

Address _____

I hereby present my claim for compensation for disability resulting from the foregoing injury arising out of and in the course of my employment and not caused by my intoxication nor by my willful intention to injure myself or another.

I hereby authorize any physician and/or hospital to release any information related to any treatment rendered me.

Represented by _____ _____
ATTORNEY/UNION AGENT SIGNATURE OF CLAIMANT

Address _____ Date _____

INSTRUCTIONS FOR COMPLETING FORM WC-5
"EMPLOYEE'S CLAIM FOR WORKERS' COMPENSATION BENEFITS"

IMPORTANT:
This claim will not be processed and will be returned if information provided is incomplete. Complete in triplicate. Keep one copy and send the original and one copy to your district office shown on the bottom of the page.

Ensure information indicated is CLEAR, LEGIBLE, COMPLETE AND ACCURATE.

INJURED PERSON:
Name: Enter name shown on your social security identification card (no nicknames).
Address: Enter mailing address.

EMPLOYER:
Name: Enter complete business name of employer.
Address: Enter full address of employer to include city, state and zip code.

INSURANCE CARRIER:
Name: Enter the name of the insurance company that handles workers' compensation for your employer.

INJURY:
Date of Accident: Enter specific date injury occurred.
Time: Specify time and whether a.m. or p.m.
Describe injury/illness: How and where accident occurred?
Reason for filing: Specify reason for filing claim.

WITNESS:
Enter name and address of someone who saw accident, if any.

NOTICE:
Did you tell your employer you got hurt?

ATTENDING PHYSICIAN:
Enter name and address of the physician who treated you for this injury and attach available medical reports to this claim.

REPRESENTED BY:
You may leave this part blank, but if you are represented, enter name and address of attorney/union agent, or other representative.

Address: Enter full address of your representative to include city, state and zip code.

SIGNATURE OF CLAIMANT:
Sign your name and date.

ATTACHMENTS: (if available)
Physician medical reports
Attorney letter of representation

HONOLULU OFFICE:
P.O. Box 3769
Honolulu, Hawaii 96812-3769

HAWAII DISTRICT OFFICE:
State Office Building
75 Aupuni Street, #108
Hilo, Hawaii 96720

WEST HAWAII DISTRICT OFFICE:
P.O. Box 49
Kealakekua, Hawaii 96750

MAUI DISTRICT OFFICE:
State Office Building
2264 Aupuni Street, #2
Wailuku, Hawaii 96793

KAUAI DISTRICT OFFICE:
State Office Building
3060 Eiwa Street, #202
Lihue, Hawaii 96766-1887

Auxiliary aids and services are available upon request. Call Records & Claims at (808) 586-9161 (voice), (808) 586-8847 (TTY), or 1-888-569-6859 (TTY neighbor islands). A request for a reasonable accommodation(s) should be made no later than ten working days prior to the needed accommodation(s).

It is the policy of the Department of Labor and Industrial Relations that no person shall on the basis of race, color, sex, marital status, religion, creed, ethnic origin, national origin, age, disability, ancestry, arrest/court record, sexual orientation, and National Guard participation be subjected to discrimination, excluded from participation, or denied the benefits of the department's services programs, activities, or employment.